Mental Health Services Referral Form

medicare local EASTERN MELBOURNE
Connecting health to meet local needs

Please tick appropriate service, attach Treatment Plan and relevant information and fax to EMML on 8677 9510

Referral Date: _____/_____/_____ **Time**: _____ **BOiMHC ID Number:** _____

- ☐ **Better Outcomes in Mental Health Care (BOiMHC)**
  Low income & disadvantaged groups (MHTP & K10)
- ☐ **Child Mental Health Service (CMHS)**
  For 0-12 years only (CTP and S & D outcome measure)
- ☐ **headspace Knox / Youth Services (YS)**
  For 12 – 25 years only (MHTP and DASS 21)
- ☐ **Bushfire Services (BFS)**
  Affected by or lives in a bushfire affected area (MHTP and DASS 21)
- ☐ **Suicide Prevention Services (SPS)** No MHTP required
  Suicidal or self harm thoughts, feelings or behaviours (Sheehan Tracking Scale)
- ☐ **Mental Health Nurse Services (MHNIP)**
  Severe & chronic mental illness (MHTP & K10 required)

AHP Name: _____
(For BOiMHC only)

GP Name: _____

Signature:_____
Provider Number:

Practice Stamp

The referring GP is responsible for the patients clinical mental health care throughout all EMML Mental Health Services
Exclusion Criteria: Eligible for Tertiary (Public) MHS including community MHS, high risk for suicide

Referrer Details (When referrer is not a GP)

(Please complete GP details and notify GP of presentation and referral to EMML services)

Referrer Name:_____ Service/Hospital Name:_____

Position:_____ Team/Service:_____

Contact No:_____ Fax No:_____

Patient Details

First Name: _____ Last Name:_____

Date of Birth : _____/_____/_____ Gender : ☐ Male ☐ Female

Address : _____ Suburb:_____ Postcode : _____

Day time phone:_____ Mobile: _____

Next of kin/guardian name:_____ Relationship to patient: _____

Medicare Number:_____ Patient MH diagnosis:_____

Patient Consent (Referral not accepted without signed consent)

☐ Patient / Parent or Guardian provides consent to treatment

☐ Consent to EMML providing correspondence to

(List services): _____

Signature: _____

Consent by (Name) : _____

Date of consent: _____/_____/_____

Suicide Prevention Services Referral Checklist:

☐ Patient is provided with **ATAPS After Hours Suicide Support Line phone : 1800 859 585** for after hours support.

☐ Referral after 3pm (Mon – Thur), on Fri, and weekend/Public Holidays → GP must call **1800 859 585** to book a callback for patient through ATAPS After Hours Suicide Support counsellor

☐ GP must fax referral to Eastern Melbourne Medicare Local on **8677 9510**

www.emml.com.au
21 – 23 Maroondah Highway Croydon VIC 3136
t 03 9871 1000 f 03 9879 5407
ABN 45 828 538 184 ACN 158 800 652

Medicare Locals gratefully acknowledge the financial and other support from the Australian Government Department of Health and Ageing

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Patient History	Does the diagnosed disorder cause significant impairment?		☐ Yes ☐ No
	Has the patient been hospitalised or at risk of hospitalisation?		☐ Yes ☐ No
	Will the patient require continuing treatment / management over a prolonged period?		☐ Yes ☐ No
Language Spoken		**Interpreter Required**:	☐ Yes ☐ No
Ability to speak English (please circle)	*NOT AT ALL* *NOT WELL* *WELL* *VERY WELL*		
Aboriginal / Torres Strait Islander	☐ No	☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander	☐ Yes - Aboriginal & Torres Strait Islander
Education Level	☐ Primary ☐ Secondary (Year 7-10)	☐ Secondary (Year 11) ☐ Secondary (Year 12)	☐ Unsure
Employment status	☐ Full time ☐ Part time	☐ Casual ☐ Unemployed	☐ Other .....
Living situation	☐ Lives alone ☐ Lives with family ☐ Homeless	☐ Shared House / Renting ☐ Own House ☐ Other	☐ Accommodation Services :- Name: ..... Type: .....
Low Income Earner	☐ Yes	☐ No	☐ Unsure
Prior Mental Health Care	☐ Yes ☐ Specify:	☐ No	☐ Unsure
ICD-10 Primary Care Diagnostic Categories (GP to fill in)	☐ F1 Alcohol & Drug Use ☐ F2 Psychotic Disorders ☐ F3 Depression ☐ F4 Anxiety Disorder ☐ F5 Unexplained Somatic ☐ Peri Natal Depression	☐ F43 Adjustment Disorder ☐ F50 Eating Disorder ☐ F60 Personality Disorder ☐ F90 Hyperkinetic Disorder ☐ F91 Conduct Disorder ☐ F93 Emotional Disorder	☐ F94 Social Function Disorder ☐ F95 Tic Disorder ☐ F98 Other Behavioural Disorder ☐ Unknown ☐ Other .....
For which focused psychological strategy is the person being referred? (GP to fill in)	**Cognitive Behavioural Therapy :** ☐ Behavioural Interventions ☐ Relaxation Strategies ☐ Cognitive Interventions	☐ Skills Training ☐ Other CBT Interventions (Specify) ..... ☐ Diagnostic Assessment	☐ Psycho - education ☐ Interpersonal Therapy ☐ Other (Specify) .....
Is the person receiving medication? (GP to fill in)	☐ Benzodiazepines & anxiolytics ☐ Antidepressants	☐ Phenothiazine & major tranquilizer	☐ Mood Stabilisers
Referral outcome (EMML ARC to complete)	Referral Accepted: Yes ☐ No ☐	Referred to:	

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